VA Natalizumab (Tysabri®) Clinical Monitoring Program
Initial Registry Information

Date of Evaluation: __ __/__ __/__ __ __ __

VAMC Healthcare Provider: _____
VAMC Provider Phone #: _____ Email: _____
Name of VA Facility: _____
VAMC Location (City): _____ State: _____ Facility/Station #: _____

☐ Check here if transferring natalizumab (Tysabri®) treatment from another VA.

Name of Patient (first, last name): _____
Date of Birth: __ __/__ __/__ __ __ __
Patient's Four Digit VA Code: __ __ __ __

Complete at the initial visit prior to starting natalizumab (Tysabri®)

1. Sex:
   ☐ Male ☐ Female
2. Race:
   ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Pacific Islander
   ☐ Asian ☐ White
   ☐ Black or African American ☐ Other: _____
3. Ethnicity:
   ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
4. Year of onset of initial MS symptoms: _____
5. Number of relapses over the past year (prior to starting natalizumab(Tysabri®)): _____
6. Indicate the MS disease modifying therapies used in the past:
   a. Interferon-beta:
      i. Avonex®: total months on therapy: _____
      ii. Betaseron®: total months on therapy: _____
      iii. Rebif®: total months on therapy: _____
   b. Glatiramer acetate: Copaxone®: total months on therapy: _____
   c. Mitoxantrone: Novantrone®: total months on therapy: _____
   d. Chemotherapy/Other: _____ (name medication) total months on therapy: _____
7. Indication(s) for Natalizumab (Tysabri®), check all that apply:
   ☐ Side effects from interferon-beta ☐ Inadequate response despite interferon-beta therapy
   ☐ Side effects from glatiramer acetate ☐ Inadequate response despite glatiramer acetate therapy
   ☐ Other: _____
8. MS Disease Subtype:
   ☐ Relapsing-remitting ☐ Secondary-progressive with relapses ☐ Progressive-relapsing
9. MS Disability at time of evaluation:
   a. Expanded Disability Status Scale (Kurtzke J, et al *Neurology* 1983;13:1444) *check box:*
      ☐0 ☐1.0 ☐1.5 ☐2.0 ☐2.5 ☐3.0 ☐3.5 ☐4.0 ☐4.5 ☐5.0 ☐5.5 ☐6.0 ☐6.5 ☐7.0 ☐7.5 ☐8.0 ☐8.5 ☐9.0 ☐9.5

      or

   b. Provider Determined Disease Steps (Hohol M, et al *Neurology* 1995;45:251) *check box:*
      ☐0-Normal ☐1-Mild Disability ☐2-Moderate Disability ☐3-Early Cane ☐4-Late Cane ☐5-Bilateral Support ☐6-Wheelchair
10. Pretreatment Brain MRI by CMSC Protocol (www.va.gov/ms) completed: ☐ Date: __ ____ __ __ __ (mo/yr)

Please FAX this form to: Alicia Sloan, MPH, LICSW, Natalizumab Clinical Monitoring Program Coordinator
MS Center of Excellence-West, **FAX: 206-277-4827**, VOICE: 206-277-3593
Questions? Email Alicia.Sloan@va.gov
Visit the MSCoE website at www.va.gov/ms Note: This is not a research protocol.